Missouri Consensus Diabetes Management Guideline for Adults Flow Sheet

Patient Name: _____ **Date of Birth:**_____

Diabetes: __ Type 1 __ Type 2 __ Other _____ **Date of Diagnosis:** _____

***A diabetes focused visit should be performed every 3-6 months or more often based on control and complications.**

Care/Test	Frequency	Date	Date	Date	Date	Date
LAB/GENERAL DATA						
Weight/height/BMI						
Temperature						
Blood pressure (medication adjustment--Goal: <130/80 mmHg)	monthly to reach goal; then each focused visit*					
Achieve A1C <7% ADA ≤6.5% AACE	2-4 times annually based on individual goal					
Measure albumin/creatinine ratio ·Type 2 ·Type 1	at diagnosis; then annually beginning 5 years after onset; or if gross proteinuria is present					
Check serum creatinine for GFR	at diagnosis; then annually					
Check lipid profile: ·Triglycerides <150 mg/dL ·HDL (men) >40 mg/dL ·HDL (women) >50 mg/dL ·LDL <100 mg/dL	at least annually; more often if needed to achieve goals					
SYSTEMS REVIEW						
Refer for dilated retinal exam ·Type 1 ·Type 2	annually 3-5 yrs after onset at diagnosis; then annually					
Oral health ·Evaluate symptoms/complaints; visual exam ·Refer for dental exam	each focused visit* every 6 months					
Foot care ·Inspect feet; stress daily self-exam ·Perform or refer for comprehensive foot exam	each focused visit* annually					
Assess cardiac autonomic neuropathy signs	at diagnosis and during review of systems					
Screen for distal symmetric polyneuropathy (DPN)	annually					
RISK FACTORS/OTHER SIGNS						
Manage cardiovascular risk factors Statins? Low dose aspirin therapy?	each focused visit* or until therapeutic goals are achieved					
Promote benefits of physical activity	each focused visit*					
Assess/advise regarding tobacco use ·Tobacco user ·Non-tobacco user	each focused visit* at diagnosis; then annually					
Inquire about alcohol/drugs	at diagnosis; then annually					
Assess/review functional limitations	each focused visit*					
PSYCHOSOCIAL						
Assess psychosocial health	at diagnosis; each focused visit*; other times as needed					
Assess social barrier adherence	at diagnosis; then as needed					
PRECONCEPTION/FAMILY PLANNING						
Provide preconception counseling	at initial visit for all women of childbearing age					
Assess contraception/provide family planning	at diagnosis; then each focused visit*					
VACCINES						
Influenza vaccine	annually in fall					
Pneumococcal vaccine	once in lifetime**					
RECOMMENDATIONS/REFERRALS						
Review self-monitoring glucose logs	each focused visit*					
Review purposes of all treatment medications	each focused visit*					
Provide and/or refer for diabetes self-management (DSMT) training	at diagnosis; then annually; more often if needed					
Provide and/or refer for medical nutrition therapy (MNT)	at diagnosis; follow-up as needed to reach goal; then 6-12 month intervals as needed					

**One-time revaccination recommended for individuals >65 who were previously immunized when they were <65 and vaccine administered more than 5 years ago.

For more specifics regarding diabetes management recommendations, please refer to Missouri Consensus Diabetes Management Guideline for Adults and supplemental information at **http://www.dhss.mo.gov/diabetes/Guidelines.html**

Diabetes 1-800-316-0935
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